ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2023-2024

ROCHESTER COMMUNITY SCHOOLS
DIABETES Care

Child's picture
Face only

This form must be completed, signed, and ATTACHED to a Diabetes Medical Action Plan (MAP). Your child's endocrinologist will choose to either use their own MAP template, OR the Diabetes MAP template listed on the RCS website.

Student's Name: _____ School: _____
Date of birth: _____ Age: _____
Grade: _____ Teacher**:** _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2023-2024 school year.

Transportation Office Use ONLY if needed
Bus # Driver: Route # Medical File

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

MASN
MICHIGAN ASSOCIATION OF SCHOOL NURSES
specialists in school health

Student Name: _____ This Plan expires June 30, 20___

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Grade: _____

Address: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Diabetes Health Care Provider: _____ Phone: _____

To be completed by Diabetes Team

Date of Diabetes Diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other:_____

SECTION I - Routine Management

Glucose Levels:

Monitoring method: ☐ Continuous glucose monitor (CGM) Type _____ **OR** ☐ Finger Stick

Preferred location: ☐ Classroom ☐ Office ☐ Where convenient

Glucose check performed by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

Check prior to: ☐ Breakfast ☐ Snack ☐ Lunch ☐ Before PE/Recess ☐ Before leaving school

☐ Ensure that glucose level is above 100 before physical activity or boarding the bus ☐ Other: _____

Always: ☑ Check when symptomatic ☑ Perform finger stick if symptoms do not match CGM values

- **If glucose level is low (< _____ or < _____ with symptoms), see Section III, Low Glucose Level (Hypoglycemia)**
- **If glucose level is high (> _____), see Section IV, High Glucose Level (Hyperglycemia)**

Insulin Administration: (Type of Insulin per Medication Administration Authorization Form, see Section II)

Preferred administration location: ☐ Classroom ☐ Office ☐ Where convenient

☐ Pen/Syringe - Dosing per: ☐ Card ☐ Chart ☐ Scale ☐ InPen* ☐ PUMP* *All settings pre-programmed by parent

Breakfast: ☐ Prior to ☐ Immediately after **Lunch:** ☐ Prior to ☐ Immediately after **Snack (carb coverage only):** ☐ Prior to ☐ NA ☐ Immediately after

Insulin dosage calculated by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

☐ Student will determine all carb counts independently **OR** ☐ Family will provide carb counts to school staff daily

☐ For foods provided by school nutrition services, school staff will ensure student/family has access to carb counts

Insulin administered by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

Adjustments to Insulin Dosing:

☐ Parents/Guardians have sufficient training and experience and are authorized by the prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments within the following parameters:

☐ Yes ☐ No Adjust correction/sensitivity factor within the following range: 1 unit:_____ to 1 unit:_____ (Target Glucose:_____)

☐ Yes ☐ No Adjust insulin-to-carbohydrate ratio within the following range: 1 unit:_____ to 1 unit:_____

☐ Yes ☐ No Increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

☐ Designated School Personnel should contact provider if parents request insulin dosing adjustments > _____ times/week.

☐ **Written communication between Provider & Parent** (e.g. emails, clinic visit summary, etc.) may be used to adjust insulin dosing until updated Insulin Dosing Tool is received by the Designated School Personnel.

SECTION II – Medication Administration Authorization (MAA) Form

This form must be completed fully in order for schools to administer the required medication. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if questions arise about the student's medications and/or related diabetes care.

Prescriber's Authorization:

Student Name: _____ Date of Birth:_____ Grade: _____

1. **Medication Name:** Insulin: ☐ Admelog ☐ Humalog/Lispro ☐ Novolog/Aspart ☐ Apidra ☐ Fiasp

   Dose: Per Accompanying Insulin Dosing Tool

   Route: ☐ Pen/Syringe (Insulin dosing per ☐card ☐chart ☐scale InPen)

   ☐ PUMP (All settings pre-programmed into pump by parent)

   ☐ InPen (All settings pre-programmed into app by parent)

   Time: Breakfast: ☐ Prior to ☐ Immediately after

   Lunch: ☐ Prior to ☐ Immediately after

   Snack: ☐ Prior to ☐ Immediately after

   Potential Side Effects: _____

   Student may self-carry insulin: ☐ Yes ☐ No **Student may self-administer insulin**: ☐ Yes ☐ No

2. **Medication Name:** Glucagon

   Route & Dose: ☐ Injection, Glucagon/Glucagen/Gvoke PFS: ☐ 0.5 mg ☐ 1.0 mg

   ☐ Auto-Injection, Gvoke HypoPen: ☐0.5mg/0.1mL ☐1mg/0.2mL

   ☐ Nasal, Baqsimi Glucagon Nasal Powder: ☐ 3mg

   Time: When severe low glucose levels are suspected as indicated by unconsciousness, seizure, or extreme disorientation with inability to safely swallow oral quick-acting glucose.

   Potential Side Effects: Nausea, Vomiting, Rebound Hyperglycemia, Other:_____

   Student may self-carry Glucagon: ☐ Yes ☐ No

☐ Please see attached supplemental MAA Form for additional medication orders. Additional training provided by a RN, PA, physician, or Certified Diabetes Educator to Designed School Personnel is required.

Prescriber's Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

Parent/Guardian Authorization:

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature:: _____ Date: _____

Reviewed by RN, PA, Physician, or Certified Diabetes Educator providing training to Designated School Personnel:

_____

Signature/Title Date

SECTION III - Responding to a Low Glucose Level (Hypoglycemia)

Below are common symptoms that may be observed when glucose levels are **low**.
Reminder: These symptoms can change and some students may not display any symptoms.
Parents **may** choose to circle their child's most common symptoms.

Symptoms of a Low Glucose Level (Hypoglycemia)

Shaky Weak Sweaty Rapid heartbeat Dizzy Hungry Headache Lack of coordination Seizure Tiredness
Loss of consciousness Pale Confusion Irritability/Personality changes Continuous Glucose Monitor (CGM) alarm/arrows
Other: _____

Actions for Treating Hypoglycemia

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
Notify School Nurse or Designated School Personnel as soon as you observe symptoms. If possible, check glucose level via finger stick. **Do NOT send student to office alone!** Treat for hypoglycemia if glucose level is: ☐ less than _____ or less than _____ with symptoms. **WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**	**Student is:** ✓ **Unconscious** ✓ **Having a seizure** ✓ **Having difficulty swallowing** **Follow Emergency Steps** 1. **Administer Glucagon** 2. **Call 9-1-1** 3. **Activate MERT (Medical Emergency Response Team)**
"Rule of 15"	**Administer Glucagon**
☐ Treat with **15 grams of quick-acting glucose** (4 oz. juice or 3-4 glucose tabs) **OR** ☐ Treat with **30 grams of quick-acting glucose** (8 oz. juice or 6-8 glucose tabs) **if glucose level is less than _____** ☐ Wait 15 minutes. Recheck glucose level. ☐ Repeat quick-acting glucose treatment if glucose level is less than _____ mg/dL. ☐ Contact the student's parents/guardians. **Then:** ☐ If an hour or more before next meal, give a snack of protein and complex carbohydrates ☐ If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level. ☐ Once glucose level is greater than _____ and student has finished eating lunch, give insulin to **cover meal carbs only.**	☑ Stay with student, protect from injury, turn on side ☑ Do not put anything into the student's mouth ☐ Suspend or remove insulin pump (if worn) ☑ Administer Glucagon Per MAA Form: ☐ Injection, Glucagon/Glucagen/Gvoke PFS: ☐ 0.5 mg ☐ 1.0 mg ☐ Auto-Injection, Gvoke HypoPen: ☐ 0.5mg/0.1ml ☐ 1mg/0.2ml ☐ Nasal, Baqsimi Glucagon Nasal Powder: ☐ 3mg ☐ Implement Medical Emergency Response: ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

Student Name: _____ **This Plan expires June 30, 20___**

SECTION IV - Responding to High Glucose Levels (Hyperglycemia)

Below are common symptoms that may be observed when glucose levels are **high**.
Reminder: These symptoms can change and some students may not display any symptoms.
Parents **may** choose to circle their child's most common symptoms.

Symptoms of a High Glucose Level (Hyperglycemia)

Increased thirst Increased urination Tiredness Increased appetite Decreased appetite Blurred Vision Headache
Sweet, fruity breath Dry, itchy skin Achiness Stomach pain/nausea/vomiting Seizure Loss of consciousness/coma
Continuous Glucose Monitor (CGM) alarm/arrows Other: _____

Actions for Treating Hyperglycemia

Treatment for Hyperglycemia	Treatment for Hyperglycemia Emergency
Notify School Nurse or Designated School Personnel as soon as you observe symptoms.	**Call 9-1-1** **Activate Medical Emergency Response**
☐ **For glucose level less than 300:** ✓ If not mealtime – do not give correction dose of insulin, offer water, return to normal routine if feeling well ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ☐ **For glucose level 300 or greater:** ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ✓ Have student check ketones ☐ **Positive Ketones:** ✓ Call parent/guardian ▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting ▪ Moderate or Large - parent pick-up immediately ✓ Give 8-16 oz. of water hourly ✓ No exercise, physical education, or recess ✓ Recheck ketones at next urination ✓ If on pump, check infusion set/pump site: ▪ Is tubing disconnected? ▪ Is there wetness around the pump site, etc.? ☐ **Negative Ketones:** ✓ If not mealtime - offer water, return to normal routine if feeling well ☐ **If no ketone strips are available:** ✓ Treat as Positive Ketones ✓ Request strips from family	☐ Call 9-1-1 if severe symptoms are present. Severe symptoms **may** include: ✓ Abdominal pain ✓ Nausea/Repetitive Vomiting ✓ Change in level of consciousness ✓ Lethargy ☐ Implement Medical Emergency Response: ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

_____ _____

Parent/Guardian Signature (Void if not signed) Date Physician Signature Date

Student Name: _____ This Plan expires June 30, 20___

To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.

SECTION IV - Food and Miscellaneous

☐ Snack daily at: _____ ☐ Snack as needed for low glucose level ☐ Allow unlimited access to food

☐ Allow unlimited access to water or bathroom ☐ Have 15 grams of quick-acting glucose available at site of physical activity

☐ For special occasions that involve food: ☐ always contact parent for guidance **OR** ☐ student can self-manage

☐ Out of classroom, student will travel with: ☐ buddy ☐ adult

☐ always **OR** ☐ when support is requested or is obviously needed

☐ Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)

☐ Plan for access to food and appropriate support during School Emergencies developed/implemented

☐ Record all care provided/send documentation home: ☐ Weekly ☐ When requested by parent ☐ Other: _____

Location of Glucagon (Glucagon/Gvoke/Baqsimi): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

Location of Other Diabetes Supplies (see attached list): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

School Name: _____ Principal: _____

School Address: _____

SSH Team consists of:

Parent, Student, Designated School Personnel

AND

RN, Physician, PA, or Certified Diabetes Educator (Trainer)

The following Designated School Personnel have received training to support implementation of this plan:

_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**

Training provided by:

_____

Signature/Title Date

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2023-2024

Student name: _____ Date of birth: _____ Grade: _____

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM
(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: _____ Reason for medication: _____

Dose (*please do not give a range*): _____ ☐ MG ☐ ML ☐ MCG ☐ Units ☐ Other: _____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Other: _____

Frequency: ☐ Daily ☐ Other (*please be specific*): _____

☐ Routine time(s) to be given: ☐ _____ AM ☐ _____ PM ☐ Other: _____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

_____

Special instructions or side effects: _____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):

☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

Student may self-carry an Epi-Pen (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received Other date: _____ ☐ For episodic/emergency events only

STOP: ☐ End of school year Other date/duration: _____

Prescriber Name: _____ Signature: _____

Clinic/Hospital Name: _____ Address: _____

Date: _____ Phone number: _____ Fax number: _____

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the district of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.

☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: _____ Signature: _____ Date: _____

ROCHESTER COMMUNITY SCHOOLS

Medication Procedures

(as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.